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ABSTRACT

This manual is designed for mental health center staff members to design effective interventions with elderly clients in short-term groups. Chapter One briefly describes a project which uses the therapy techniques of Cognitive Restructuring Therapy (CRT), Transactional Analysis (TA), and Life Review with groups of elderly persons to determine their efficacy in decreasing anxiety and depression levels and improving their quality of life. Detailed session-by-session descriptions of the three intervention strategies are given in Chapters Two (CRT), Three (TA), and Four (Life Review). A list of recommended readings that provide background information is included at the end of each chapter. Chapter Five provides further information about the project and summarizes results and conclusions. A comparison of nursing home residents, the community elderly in the project, and a no-intervention control group is included. The appendices contain forms and worksheets from the project. (NRB)

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SHORT-TERM COGNITIVE GROUP THERAPY WITH ELDERLY CLIENTS:

TRAINING MANUAL FOR MENTAL HEALTH PROFESSIONALS

University of Denver (Colorado Seminary)
School of Professional Psychology

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Editors

August 31, 1981

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DEDICATED TO THE ABOLISHMENT OF SOCIETY'S MYTHS ABOUT THE ELDERLY

ACKNOWLEDGEMENTS

This manual represents the contributions of many persons of varied backgrounds, vocations and ages. The editors have tried to preserve and integrate the ideas of all who participated in the project. We regret that we cannot convey everything we have learned in our work with the elderly or thank all of those who have been our teachers.

We wish to thank our consultants, Rian McMullin of the Counseling Research Institute of Lakewood, Colorado, and Thomas Giles of Temple University for their invaluable guidance and professional expertise.

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We wish to thank the administration and staff of the Bethesda Community Mental Health Center, particularly Martin Dubin. Mark Grimm and his staff at the Jefferson County Mental Health Center were also welcome participants and consultants over the course of this project.

We would like to express our gratitude to the students, staff and faculty of the School of Professional Psychology for their encouragement, suggestions and support. Special thanks go to Phillip Thomsen for his ability to quickly acquire the considerable degree of technical skill needed to capture our group leaders' efforts on video tape. Finally, we thank Adelaide Cohen and Joanne Broten for help with editing, typing and proofing so that others might benefit from the work of those mentioned here.

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August 31, 1981

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CHAPTER 1. INTRODUCTION

The Secretary's Committee on Mental Health and Illness of the Elderly (1979) emphasizes that mental illness is more prevalent among the elderly than among younger adults. Research shows that 15 to 25 percent of the elderly have some significant mental illness, and the Committee estimates that 60 percent of the elderly will suffer a significant mood disorder such as depression or anxiety at some time.

Persons 65 and older are subject to multiple life stresses. Losses due to changes in social supports, status and physical decrements are greater than at any other phase of the life span. Further, the aged person may attribute societal myths and stereotypes about aging to him/herself. Therefore, many elderly persons consider themselves senile, worthless and helpless. The elderly may also hold stereotypes about mental health services which mitigate against their seeking these services (Lawton & Gottesman, 1974; Cohen, 1976).

Given that mental health services for the elderly are limited and are likely to remain so for some time and that the elderly are generally reluctant to seek these services, treatment strategies are needed which can be extended to as many older persons as possible. Such strategies require effective brief therapy techniques which 1) are readily taught to mental health professionals, 2) can be used for groups of elderly persons, 3) are congruent with the concepts of self-improvement and "quality of life" so that elderly persons will enroll in the groups and 4) are self-maintainable by the clients following the direct intervention period.

There are three cognitive intervention approaches which meet these criteria and also hold promise for effective intervention with the elderly (Butler, 1975; 1977). One approach is Cognitive Restructuring Therapy; another is the Transactional Analysis model; and the third is the Life Review.

Background: The School of Professional Psychology was among the first clinical psychology training programs to require students to study the complete life cycle. We are, therefore, familiar with the multifaceted biological, social and psychological problems common to elderly persons (Paley, 1979). Students at the school have gained valuable experience in providing training to the staffs of nursing homes and community mental health centers (e.g., Paley & Dea, 1979).

Current Project: Our most recent project involved using the therapy techniques listed above with groups of elderly persons to determine their efficacy in decreasing anxiety and depression levels and thus increasing the quality of life. The project consisted of three phases. During Phase I (Direct Service) the project staff selected two mental health centers for participation. The administrations of the Bethesda and Jefferson County Community Mental Health Centers then each chose one senior center within their catchment areas as the site for weekly groups with elderly clients.

A publicized general meeting was held at each senior center to explain the general theme of "Life Exploration and Enrichment" to prospective participants. All who agreed to participate completed the Beck Depression Inventory

(Beck, 1979)[1], the Speilberger State-Trait Anxiety Inventory (1970)[2] and an Activities of Daily Living behavior rating.[3] To avoid bias in client responses and congruent with the theme of the groups, these were retitled Life Satisfaction Questionnaires I, II and III. At each center clients were randomly assigned to one of the following groups: Cognitive Restructuring Therapy (CRT), Transactional Analysis (T.A.), Discussion/Life Review, and a no-intervention control group. Each therapy group met weekly over the ensuing eight weeks for one and one-half hours per session. Segments of each session were videotaped to assess progress and for use in the second phase of the project. Assessment instruments were again administered at the last session of each group, as well as at three months post-intervention, for follow-up.

During Phase II (Training Mental Health Center Staff), project staff worked with selected staff members of the two mental health centers in order to train them in conducting the cognitive group interventions used in Phase I. These trainees subsequently applied these methods in group therapy with elderly clients enrolled in their respective centers. School of Professional Psychology staff served as supervisor-consultants during the latter phase. Pre- and post-tests were administered to the trainees to assess knowledge about the elderly (Facts of Aging, Palmore, 1977) and their cognitive rationality (Bard, 1973).

As the project progressed we became curious about the differences between the community elderly with whom we were working and the residents of nursing homes. Therefore, we enlisted the help of two nursing home administrators to give questionnaires to their most highly functioning residents.[4] These were given at two intervals, at the beginning and completion of eight weeks, so that residents could be compared with both the groups and the no-intervention controls. Results will be found in Chapter 5.

During Phase III we prepared this manual which outlines two of the therapy techniques adapted and utilized in the project and discusses the third. It is our hope that this manual will be useful to mental health center staff members for effective intervention with elderly clients via short-term groups. The manual appears to be a useful adjunct to inservice training because of the relatively detailed session-by-session descriptions of the intervention strategies.

Manual Guide: Particular attention should be given to the list of recommended readings at the end of each chapter since these provide background information which has not been included due to space limitations.

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1. The Beck Depression Inventory was used with the permission of the Center for Cognitive Therapy, Aaron T. Beck, Director, 133 South 36th Street, Philadelphia, PA 19104.
2. Speilberger, C.D., Gorsuch, L., and Lushene, R.E. STAI Manual, Consult-Psychologists Press, Inc., Palo Alto, CA 94306.
3. The project staff constructed this instrument particularly to measure social interaction. It is reproduced in Appendix A (Goldstein, 1980).
4. Appreciation is extended to Kay Hunter, Valley Manor Nursing Home, and to Janet Walker, Holly Heights Care Center, and to their participating residents.

Chapter 2 describes Cognitive Restructuring Therapy (CRT). The focus of CRT is psycho-educational. Chapter 3 outlines the use of Transactional Analysis (T.A.). The focus is on developing group social supports through the use of structured experiential exercises. Chapter 4 summarizes our experience using the Life Review process and Chapter 5 summarizes our results and conclusions.

The editors would appreciate hearing from those who use this manual as to its utility and the results of applications of the techniques described herein.

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CHAPTER 2. COGNITIVE RESTRUCTURING THERAPY

Michael A. Goldstein, Andrew Sweet and Thomas Giles, consultant

CRT is a direct outgrowth of the work of Albert Ellis (1962, 1971, 1973), who contends that people see the world through "cognitive filters" so that feelings and behavior are the direct result of an interpretive cognitive process. The basic model is:

A----------B----------C
Antecedent Event Belief Consequent feeling or behavior (Ellis, 1974)

The model proposes that B, the belief, is the agent responsible for behavior and affect. Problematic emotions are not assumed to be inevitable consequences of particular events, but the result of what people say to themselves about these events. Environmental stresses are considered to be "antecedent events."

Such stressors are more pervasive for the elderly than for any other age group. An overwhelming multitude of potentially traumatic events, e.g. losses of spouse and friends, declining financial status and health problems may befall the older person. The response to events is crucial in determining the eventual status and stability of mental health (Butler, 1975; Butler & Lewis, 1977). To the extent that environmental stressors cannot be prevented, it would seem to be effective to teach the elderly cognitive "inoculations" as a means of reducing, alleviating or even preventing psychological distress.

CRT interventions in both individual and group settings have been extensively documented. This program is a direct outgrowth of theoretical and therapeutic systems developed by previous researchers (e.g., McMullin & Casey, 1975; Casey & McMullin, 1976; McMullin & Giles, 1981). We have drawn heavily on their therapy "packages" and have modified them for teaching CRT principles and techniques to groups of elderly persons. This program was presented to two separate groups.

We chose to apply the phrase "cognitive restructuring education" to the 8-week workshop in order to emphasize an educational approach. While the CRT approach was initially developed for use in a therapy setting, the current project was intended as a test of the usefulness of these methods in a non-clinical setting.

In addition to presupposing a basic understanding of group therapy process and a basic familiarity with the cognitive-behavioral approach, we recommend that prospective group leaders become thoroughly familiar with the references for an understanding of the underlying rationale and explication of the technique. An invaluable resource for both group leaders and participants is Talk Sense to Yourself (TSTY) (McMullin & Casey, 1975). It was used as the basic reader in our groups with a number of significant modifications. While the approach is generally consistent with ours, they use a number of terms (e.g., "irrational") which we avoided, and they present numerous techniques (e.g., "logical analysis") which we have either simplified or entirely omitted based on our experience in conducting groups with elderly persons.

We make frequent references to a "Workbook" and to "Homework Assignments." We developed these materials and they are included in Appendix B.

Session-by-session outline of Cognitive Restructuring Education Program (CRE):

Session #1: Introductions (leaders introduce selves, backgrounds; members introduce selves; attendance is taken; basic introduction to CRE

Rationale for using this approach:

- this is education for life enrichment, not therapy
- this is a proven method with a strong research background
- (optional*) compare CRE with other approaches
- (optional*) cite physiological evidence (McMillan & Giles, 1981)

Present Group Ground Rules:

- no interruptions; everyone will have a chance to talk
- not necessary for members to volunteer personal information

Give Out Workbook:

- a set of exercises designed to facilitate learning basic principles and techniques of CRE

Basic ABC Lecture:

- discuss the differences between events, thoughts and feelings; use blackboard; examples in Workbook; members complete one together (p. 1, Appendix B)
- discuss differences between physical and psychological discomfort
- define and diagram the ABC's of thoughts and feelings
- emphasize that C may be both a feeling and a behavior
- address the issue of "changing the A"; give examples using both physical and psychological discomfort
- emphasize that this is sometimes possible with psychological discomfort, but what if we can't change the situation?
- teach the use of easy "ABC Questions:"
    - for A: "What happened out there?"
    - for B: "What's going on in my head?"
    - for C: "What am I feeling in my gut and what am I doing?"

Group Leaders Give Brief Talk on "Pitfalls:"

- 2 main pitfalls are missing sessions and not doing homework
- success with these methods is completely dependent on effort

Assign Homework (HW) #1 (Workbook, Appendix B):

- explain reading assignment in Talk Sense to Yourself (pp. 1-17)

*These sections are not essential to the program but are highly recommended when they seem relevant to the particular population and when time permits.

- clarify differences between TSTY and this program
- explain the homework exercises; have people read them and ask questions

Group Leader Guidelines:

- convince participants of leaders' expertise
- convince participants of efficacy of this approach
- explain basic therapeutic concepts with minimal "jargon"
- try to conduct sessions using an informal style - use humor
- show empathy for clients' problems without dwelling on them: "It's too early to begin work on individual problems."
- non-punitively cut off irrelevant or pessimistic comments
- reinforce on-task questions, comments and genuine efforts
- feed back questions and comments in CRE framework, e.g., "So you're scaring yourself by worrying about possible negative consequences."
- for small group exercises: Break into small groups, each with a trained leader to guide exercises, model appropriate responses and shape responses by reinforcing "successive approximations."
- explain homework assignment so that participants know what they are expected to do
- attend to members' interest level; are they understanding you?

Session #2:

Take Attendance

Repeat ABC Lecture answering questions as they arise

Small Groups: Review HW #1 in detail; reinforce completed HW, "troubleshoot" individual member's difficulties

Give Talk on "6 Categories of Trouble Beliefs" (cf, TSTY):

- use pictures in TSTY (pp. 19-24) as general examples
- ask for personal examples
- emphasize that different people may have similar feelings which are caused by very different thoughts; there is no 1:1 relationship between a given thought and a given feeling; give examples

Workbook Session #2 (Appendix B):

- have participants come up with an example of each thought; write it in book with resultant feeling and action

Small Groups: Participants discuss the 6 categories, sharing individual troublesome thoughts and feelings

Assign HW #2 (Appendix B) and explain

Group Leader Guidelines:

- be 100% confident that everyone understands the basic ABC's; recommend

1:1 sessions as "catch-up" for those having difficulties
- avoid "pigeon-holing" members' thoughts into specific categories (e.g. "Namby-Pamby" or "Doomsday"); thoughts are never either/or; assess which feelings and behaviors accompany particular thoughts; the 6 categories are mainly for illustrative purposes and are a helpful distancing technique
- address particular "sabotages" or pitfalls as they occur (e.g., member who discounts everything group leaders say or who says "this isn't helping me!")

Session #3:

Take Attendance

Small Groups: Review Homework #2 in detail

Give Talk on "Analyzing Your Beliefs" (This is a 5-step procedure in TSTY (pp. 28-30) which we have simplified to 2 steps: "Now that we've seen how our thoughts may produce our unpleasant feelings, how can we begin to change?"

1) "State Your Case" - a useful format for analyzing B's: "I feel __C__ because __A__." (cf TSTY, p. 28: the "should" was deleted from this format because of its negative connotations and the logical fallacy inherent in any B containing a "should")

2) "Define Your Terms" - the words we use structure our thoughts, so it's essential that we know their meanings; therefore, we'll use a dictionary to define key terms in our B's

- give several examples of both steps for a common B

Small Groups: Workbook Session #3 (Appendix B):

- each analyzes 2 upsetting situations (A, B, C) which have recently occurred

Give Talk on the "5 Questions" - these are used to give you a handle on whether or not a particular B is helpful

1) Does this belief help me feel better?
2) Does this belief help me accomplish my goals?
3) Does this belief help me to get along with others?
4) Would everybody have the same belief in this situation?
5) Do I always feel this way in such situations?

- if the answer is "No" to any of these 5 questions, then this B is not helpful and it deserves to be replaced!
- group leaders do at least 1 complete analysis using the 5 Questions

Assign HW #3 (Appendix B):

- explain reading assignment and exercise

Group Leader Guidelines:

- stress importance of learning to analyze B's: "We're laying the foundations for working on your problems"
- avoid "splitting hairs" when defining terms; the 2 main goals of this procedure: 1) to substitute more neutral words for the emotionally-laden ones; 2) to find words which may be operationally defined (e.g., not "bored" but "inactive")
- group leaders may find it necessary to prompt members to come up with troublesome thoughts; if so, and you have some idea of their troubling C's, ask about these (e.g., "Did anything happen last week that made you feel _____?")
- hint: you only need an A or a C to begin tracking down the B's!

Session #4

Take Attendance

Small Groups: Review Homework #3 in detail

Give Talk on "How this all fits together" and "How can this help you deal with troublesome feelings and thoughts?"

- integrate ABC theory, "State Your Case," "Define Your Terms," and the "5 Questions": all are means to examine thoughts to see if they are helpful to us or not

Small Groups: Workbook Exercise: Come up with 5 A's in the last month that have been upsetting

- each person does a complete analysis of 1 of these A's

Assign HW #4 (Appendix B)

Group Leader Guidelines:

- leaders act as facilitators/"shapers" to help participants to complete Exercise; make sure they are stating their B's in a meaningful form before asking the "5 Questions"
- leaders may volunteer personal or "bogus" examples to illustrate this process, common problems (e.g., not clearly specifying the C for a particular B: "Do you feel more angry or sad when you think about that?")
- it's essential that people become facile in analyzing their thinking, as this is the prerequisite to changing problem thoughts

Session #5

Take Attendance

Small Groups: Review HW #4 in detail

Talk on Hierarchies: "By now you know what some of your troublesome emotions

are, which situations produce the thoughts that cause problems; we will help you make up an ordered list of these situations in order to enable you to systematically attack your problem thoughts."

- use example of a hierarchy (see p. 40 in TSTY)

How to Construct Hierarchies:

1) Each hierarchy is made up of sets (A's) which elicit 1 particular feeling (e.g., "guilt")
2) The situations must be specific enough to be clearly "visualizable"
3) The ranking of situations proceeds in small steps of "upsetness" from the least to the most upsetting situation
4) There should be no "jumps" in the target feeling, rather a gradual, step-by-step increase as you proceed up the hierarchy (use "staircase" analogy, TSTY, p. 40)

Leaders Provide Examples of possible hierarchies; write them on blackboard; begin with the #0 and #10 situations as "anchor points"

Small Groups: Session #5 in Workbook (Appendix B):

- each person picks a "target feeling" and begins by filling in the #0, #5 and #10 items; have them transfer these items onto HW #4

Assign HW #5 (Appendix B): Complete hierarchy begun today; optional: begin a 2nd hierarchy for a different emotion

Group Leader Guidelines:

- people often have trouble finding appropriate A's to fill in a hierarchy; suggestion: have them list many different A's which produce the trouble C, then rate these from 0-10 and fill in the hierarchy
- the 3 most common problems with hierarchies are: 1) not keeping the items at equal "upsetness" distances, 2) items resulting in emotions other than the target one are mistakenly included and 3) people writing general and/or vague items rather than specific situations
- if a given item elicits more than 1 emotion, have them place it in the hierarchy of the strongest feeling
- stress that "everybody's hierarchy will be different"
- hierarchy items may be situations which have actually occurred or those which could occur in the future

Session #6

Take Attendance

Small Groups: Review HW #5; if there are many mistakes on hierarchy #1 or if they did not fill in #2, have them complete both for next week (give suggestions as needed)

Review hierarchy concept and rules; use examples on blackboard; trouble shoot; go back to "basics" if needed

Lecture on Counters - to provide them with a way to replace problematic thoughts with more adaptive ones

- give examples of counters for common thoughts
- point out that hierarchy item #0 causes no real discomfort because they can already come up with counters for it (e.g., "Oh, that's silly!")

Rules for Countering:

1) counters are opposites, not compromises; they directly contradict the troublesome B
2) they are believable statements of reality, not lofty intellectualizations
3) expect to have competing thoughts, but keep countering!
4) counter strongly and frequently, using emotional tone of voice and gestures
5) use the "Basic Counters" if you get stuck (TSTY, pp. 36-37)

Explain Notion of "Level of Affective Discomfort" (LOAD):

- the troublesome emotion elicited by a B may be rated on scale of 0-10
- the LOAD will gradually decrease with practice of counters

Small Groups: Exercise: using their primary hierarchy items #0, 1 and 2, have them state their B and A for each (note: it may be the same B, but this is worth having them discover for themselves); see Workbook Exercise #6

- for each item, list 3 counters; follow the rules!
- counters may be the same for several B's, but it's helpful to develop a repertoire of many possible counters

Assign HW #6 (Appendix B) - come up with 3 counters for hierarchy items #3, 4 and 5; use those rules!

Group Leader Guidelines:

- give many examples of "strong" counters; model countering (even raise your voice a little!)
- research shows that using emotional tone and gestures helps to "ingrain" the counters more than rote memorization
- don't allow them to practice "countering their counters" (this is counterproductive!); avoid giving undue attention by arguing with members
- encourage them to help each other invent counters

Session #7

Take Attendance

Small Groups: Review HW #6

Lecture on "Challenging" Your Thoughts: a proven procedure for practicing countering

- for a given hierarchy item, their LOAD will tend to decrease if they use this "challenging" procedure

Demonstrate Procedure with Co-leader in front of group; see "Procedure for Challenging" in Workbook

- encourage questions from group

"Group Challenge" - using item #1 from their primary hierarchy; leader reads procedure aloud, members practice silently

Small Groups: Discuss reactions to "Group Challenge" - leaders "float" and troubleshoot, making sure the procedure was followed and understood

Dyadic Exercise - using their lowest remaining hierarchy item (i.e., that which produces 1 or more LOAD-units), have them guide each other through one round of challenging by reading the procedure aloud

- leaders "float" and coach members in proper pacing of the procedure; all rehearsal is done aloud at first and is faded out as skill is gained

- suggest that they start with their lowest item and not move "up" the hierarchy until their LOAD has decreased to 0 for that item (i.e., it no longer "upsets" them)

Explain Use of the "Challenging Practice Sheets" (Homework #7)

- 2 purposes: 1) to help structure practice and 2) to help chart progress (or problems) as they continue using the procedure

Assign HW - Using "Practice Sheets", practice for at least 10 minutes per day

Group Leader Guidelines:

- note that the "Challenging" procedure is called "VCI" (Voluntary Cortical Inhibition) in TSTY (p. 41)
- plan to spend at least 10-15 minutes on the demonstration
- the person role-playing the "client" should vocalize self-statements (both B's and counters); it's especially helpful to model some examples of "weak" countering; have the "therapist" correct these
- when assigning HW, try to get each person to state publicly when, where and for how long s/he will practice each day

Session #8 (Final Session)

Take Attendance

Small Groups: Review HW ("Practice Sheets") - troubleshoot; ask questions; repeat lecture points as necessary

Large Group Challenge - same procedure as in Session #7; each member uses his/her lowest remaining hierarchy items

Answer Questions, Solicit Feedback on the Sessions

Pot Luck Party

Final Good-byes

Group Leader Guidelines:

- encourage participants to share success stories; attribute their success to their effort in learning and practicing these methods
- encourage them to use each other as "resources" after the sessions have ended (e.g., trade phone numbers)
- "refresher courses" would be a valuable addition, perhaps after 1 month, 3 months . . .
- explain that while "repeat customers" seeking individual help are welcomed, they can expect to be asked, "Have you been doing your homework?"
- enjoy the party . . . it's uniquely reinforcing!

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CHAPTER 3. THE TRANSACTIONAL ANALYSIS (T.A.) MODEL

Karen Brown and Rick Long

T.A. is a contemporary model developed by Eric Berne who rebelled against the rigid, slow, complicated, verbose and disease-bound underpinnings of psychoanalysis. T.A. emphasizes fairly rapid change, an understandable language and the individual's capacity for growth and actualization. It is primarily a decision model of personality development which assumes that we all begin "OK." People develop problems in response to the powerful influence of parental figures. Each person develops a life plan which results in childhood decisions that strongly determine life patterns and daily transactions with other people. While early choices are made about life, adults have the power to change as new, more accurate information is developed. T.A. focuses on the individual's responsibility for the choice to either change or remain static. A contracting model allows for the identification of desired changes, and participants attain measurable indications of accomplished changes.

A basic assumption is that verbal and non-verbal transactions (strokes) between people influence whether they develop maladaptive or adaptive behaviors or emotions. Negative stroking, from friends, family or society at large, devalues cognitive appraisal of self-worth, while positive stroking increases spontaneity, self-esteem and interpersonal intimacy. All transactions originate from one of three ego states: Parent, Adult or Child. Parent messages can be nurturing, controlling or directing. Adult messages reflect rational information-based processes and are largely devoid of emotionality. Child messages mainly reflect feeling states of the organism. This process is outlined in detail in Berne (1964, 1972).

The communication emphasis of T.A. helps clients to see it as non-threatening and relevant to their lives. Emphasis is placed on encouraging group members to experience their feelings, to identify the source of these feelings from Parent, Child or Adult ego states and to engage in problem solving. In combination with exercises, T.A. is useful for increasing self-esteem, autonomy, risk-taking and for making choices in one's life. It is a vehicle for dealing with the personal and societal myths of the elderly and offers a structure for "decontamination" of these faulty messages.

Increased social contact and social supports can enhance the quality of life and may alleviate the depression, anxiety and purposelessness some of the elderly experience. Group contact, social supports and experiential learning through exercises are important components to the benefits accrued in the T.A. group process. New roles, ideas and activities can be attempted in the safe group atmosphere.

Session-by-session Outline:

The overall sequence should be retained, although individual ideas or exercises may be deleted/added/moved as the session or group situation warrants.

Session #1

Introduction: Explanation of Format

1) purpose of group is to help people enrich their lives
2) outline meeting times and number of sessions; ask members to mark the dates in their calendar or planning book. Emphasize importance of regular attendance
3) group meetings will consist of exercises, presentations of material and discussion; a number of different exercises will be done over the next few weeks; members have option to participate actively or not participate

Explanation of Group Goals

1) increased understanding of self and others
2) improved communication and increased positive interactions with others
3) increased options for solving problems and making decisions
4) sharing of information about aging and ways to cope with the stresses of being an older person
5) increased personal responsibility for feelings and behavior
6) having fun!

Exercises

1) get together in twos with the person whom you know the least in the group
2 both persons mention three things they really like about themselves
3) when this is completed, the group is asked to pretend it is the first day of kindergarten; each pair takes turns being a mother (or father) and child; the parent introduces the child to the class telling the three things learned about the other; then they switch roles
4) encourage acting
5) afterwards discuss how they felt during the exercise: i.e., how did they feel when they told their partner about the three things? how did they feel being introduced to the class?, etc.

Lecture and Discussion

1) leaders tie in exercise with small lecture on stroking (see Appendix C for definition)
2) present Parent/Adult/Child concepts (Appendix C) on pad or blackboard
3) discuss accepting and giving strokes

Homework for Next Session

1) notice what kind of strokes are received from others; how are these related to your needs?
2) what would you like to change about yourselves?

Comments to Facilitators

1) consider use of name tags for each member (for first two meetings)
2) the important goal of this session is to help members to know one another and build trust
3) encourage members to "get into" the exercise, allow them to enjoy the exercise and have fun
4) don't give too much information - the interaction is primary
5) give out names and phone numbers of the group members

Session #2

Brief review of P-A-C/strokes from last session

Discuss homework from last session: how do members get and give strokes?

Leaders give small lecture on "stroke economy"

1) verbal stroking/physical stroking
2) discuss physical stroking; examples: babies need physical stroking, adults often neglect this need for selves - discuss values about touching
3) mention that backrubs are gifts that can be exchanged with people we care about

Exercise

1) members break into pairs and exchange backrubs
2) afterwards discuss this in context of both giving and receiving strokes:
   - with which were you more comfortable?
   - how come?
   - is that typical of your life?
   - how do you feel about that?

Introduction to Contracts (Appendix C)

1) there may be parts of your life that lead you to be uncomfortable and which you want to change
2) in the group we want to begin to look at what you might want to change
3) when the group is finished, imagine how you will be feeling, thinking and behaving differently so that your life will be more satisfying and joyful. How will you know when you reach your goals?
4) we'll discuss these more next week

Homework for Next Week: think about what kinds of strokes you are now getting: where? from whom? how? how could you "fill the gaps?"

Comments to Facilitators

1) the backrub exercise should grow out of the discussion of the importance of touching and physical stroking

2) socialization at the beginning is important to the group process
3) keep discussion of contracts limited; introduce it only
** 4) speak of "things to think about" rather than assignment or homework **

Session #3

Go over Homework from Last Week

1) what strokes are you getting? missing? (or, what kind/type of strokes did you receive last week?) group leader participates
2) discuss: any commonalities in strokes received? missing? what can you get from other group members?

Contracting (Appendix C)

1) explain contracts and tie to previous material
2) mention that contracts can be changed at any time
3) steps:
- what would you like to change about yourself?
- how will you be different? how will you/we know? how will you feel/think/behave differently?
4) write each member's contract and give each a copy

Homework: think about ways you have stopped yourselves from reaching your goals in the past

Comments to Facilitators

1) it is important to discuss the strokes you receive
2) contracts take a long time; encourage members as some may not be used to sharing information about themselves; also, avoid making parent contracts - encourage child ones, i.e., what they really want rather than "should" do
3) try to make contracts concrete for observable changes
4) prioritize: which of these would you like to accomplish most? assist each group member in turn to make contracts using these principles

Session #4

Exercises

1) members close eyes; relaxing music is played while members are instructed to pretend to be taking a bath and washing themselves
2) discuss as one way to self-stroke; what did members like about the exercise? what are other ways to self-stroke?

Present Lecture on Self-Stroking

1) what is very special about you?
2) it's important to get strokes from yourself as well as from others
3) integrate and discuss: what prevents us from self-stroking?

Review Homework from Last Week

1) how have members stopped themselves from reaching goals in the past?
2) how can they avoid making the same mistake again?

Discussion of Contamination (Appendix C)

1) sometimes we assume certain things to be true without really examining them; older people have this problem because society has a lot of false beliefs about aging; let's look at some of these to see what is really true and what isn't
2) myths
   - you can't teach an old dog new tricks
   - all old people are senile
   - most old people have no interest in or capacity for sexual relations
   - most older people are irritable and unhappy
   - most older people are isolated and withdrawn
   - wrinkles, brown spots, grey hair, losing hair are bad or ugly
3) ask group for others
4) refute these and then discuss normal aging, including
   - normal decline with age in the senses, weight, motor functioning
   - but you can still be very active; discuss activities
5) ask for feedback - have we left out anything that older people might be concerned with?

Think About for Next Week: what are some of the positive aspects of getting older?

Comments for Facilitators

1) fantasy exercise is a warm-up and a way of introducing self-stroking - exercises and lecture can be exchanged, depending on group
2) a blackboard or large pad is very handy

Session #5

Discussion

1) what are some of the positive aspects of getting older? record ideas on board or pad (See Appendix C for examples)
2) stress that old age grants much freedom not available before - give examples - ask for some from group
3) what do you want to do with this freedom?
   - each contract is a way of taking charge of your life and putting it under Adult Control - it's a way of parceling out P and C and taking both into account (what the person feels they should do and what they want to do)
   - myths are early programmed messages that are ready-made - relate myths to the idea of contamination
   - it's important to check out ideas/feelings about goals - some aspect of the P or C may keep us from reaching our goals

Review Contracts with Each Member

1) ask one person to work on the contract - then go on to others
2) try to clarify contracts where needed - identify wants from the Child and look for contaminated messages
3) what were the things that you wanted?
4) how are you getting them?
5) what's keeping you from your goals?
6) what are you doing to stop yourself from reaching your goal?

Comments for Facilitators

1) brainstorm with the group about the positive aspects of aging and develop a list to which they can refer (See Appendix C for examples)
2) in reviewing contracts, it may be useful to stress the importance of ego states again, for example:
   - is that what they really want? (Child)
   - or are they doing what they should do? (Parent)

Session #6

Review: strokes given/received/experienced during the past week and contracts that a member wants to mention

loss

1) older people often have concerns about how best to handle losses such as leaving a marriage, a decline in hearing or eyesight, moving to a new location, the death of a loved one, etc. - share what has been written in order to see if it fits with the group members' experience
2) remember that with each loss there is a gain, or some positive aspect - refer to the list of positive aspects developed last week regarding growing older
3) persons are always going through loss - review the life cycle and point to examples:
   - the infant gives up symbiosis for autonomy
   - the young person gives up independence for the mutuality of a partner
   - the retiring person gives up work for greater freedoms with less responsibility
4) review stages of adjusting to loss: shock/denial, anger, sadness, acceptance - describe each briefly
5) does this fit with your own experience with loss?

Healing Process

1) healing takes time and is a natural process
2) what are some ways to aid this process? - make list
3) make suggestions:
   - share feelings with a friend
   - do not push yourself during the healing period: take it easy, get enough sleep, take very good care of yourself - stroking is important here
4) ask the group for others, i.e., keeping busy, joining activities

Comments for Facilitators: use group process in discussing these issues - they'll have examples, experiences and strategies to share

Session #7

Exercise

1) pin large sheets of paper on the back of each member and each leader
2) each person is given a crayon and asked to go around to each person and write down what they like about him/her
3) afterward, the group shares what was written on each sheet
4) discuss how each feels about the feedback received

Scripts (See Appendix C)

1) scripts are like life plans that we form when we are young - we can change them in adulthood
2) they are often formed in response to pressure experienced as a child and they often endure even though they may not fit any longer or may be uncomfortable
3) they are somewhat like guiding fairy tales, to which a person tries to model his/her life
4) examples:
   - a woman who wouldn't do anything for herself until her children had grown up
   - scripts can run out when one is older, e.g. a man whose script was to raise his children and see them off to college - what happens when this is accomplished?
5) what are some alternatives to these scripts? - discuss
6) as adults we can revise or supplant our scripts, which is similar to taking control via contracts

Review Progress on Contracts

1) how do your contracts fit with your view of the future?
2) discuss specific contracts and possible revisions
3) how are group members doing with their contracts? any changes noticed? (group can share observations on this)
4) how can they make your life more enjoyable in the years to come?

Comments to Facilitators

1) the point of discussing scripts is to deal with life planning
2) be prepared to discuss the issue of the group continuing and possible alternatives

Session #8

Asking for Strokes

1) is it acceptable to ask for strokes from others?
2) personal needs re: strokes are determined from stroke economy

3) possibilities:
   - asking for what you want (vs. demanding) - risk: may not receive
   - may want to build up to asking for what you want
   - other possibilities?
4) the way you ask is very important

Final Review of Progress on Contracts: share what leaders have noticed in the group re: progress

Reminiscing

1) think back over the last seven weeks - share feelings about the group and about each other - how was it to be a member? what was special? what did you like?
2) is there anything you would suggest to improve the group or to make it more helpful?

(Optional) Continuation: discussion, if appropriate, about continuation of the group on some basis - group members given total control of this decision

Termination

1) share feelings about being in the group
2) leaders say "good-bye"

Comments to Facilitators: utilize group process - encourage sharing and personal feedback

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CHAPTER 4. "LIFE REVIEW": THE DISCUSSION GROUP

Jean Bevis and John Kurkjian

The principles of the Life Review are based primarily on the work of Robert Butler, who was the first to demonstrate that there were important functional aspects to the process of reminiscing (Burnside, 1979). Previously, the act of "looking back" was seen as "aimless wandering of the mind" (Butler, 1963, p. 66), as evidence of the older person's inability to live in the present or even as an indicator of the presence of short-term memory loss.

Butler pointed out that reminiscing is a universal and naturally occurring phenomenon, seen predominantly in the elderly, but also seen in younger people who face profound crisis, including death. It may be the sense of impending death that promotes this process.

In the therapeutic process of reminiscing, the person is able to review the totality of his/her life, in what Burnside (1978, p. 242) terms "taking stock." This helps the person in many ways. Often old conflicts are reworked and resolved when reviewed from a new vantage point. Also, one can look back to previous coping styles which may again be useful in facing current life stresses. The life review further helps preserve a sense of stability and self-identity, critical to older people who face a fast-changing world and, often, profound changes in health, marital and economic status.

The process of life review can be pleasant and satisfying in and of itself. Burnside (1978, p. 574) recognizes this and quotes Kahlil Gibran:

> "The things which the child loves remain in the domain of the heart until old age. The most beautiful thing in life is that our souls remain hovering over the places we once enjoyed ourselves."

There are also risks in conducting a life review. It can lead to feelings of regret, self-rejection and hopelessness. Butler and Lewis state (1977, p. 50): "The most tragic life review is that in which a person decides life is a waste." However, even the negative aspects of one's life can be put in proper perspective if the life review is done with an objective listener, and it can be most effective if done in groups (Marshall, 1974).

Often a group will meet with the original intention of conducting only life review but will evolve into a group with new and different foci. This was true with our groups, parallelling one of Burnside's experiences: "In one case the group met initially to reminisce and as they became more involved with one another they began to discuss daily concerns, present situations with families . . . and so forth" (Burnside, 1978, p. 243).

Our Experience: The life review process does not lend itself to the kind of structure utilized in the two therapy techniques discussed earlier. In our initial meetings with our two groups we presented the idea, noting that our culture offers little opportunity for and places little value on reminiscing about "the good old days." We suggested that comparing life experiences with others might be useful in allowing participants to take a fresh look at their pasts which might lead to a new perspective on the future. We suggested

topics mentioned by Butler (1963, 1963) and Burnside (1978) as well as some of our own ideas and asked for additional suggestions from the members. We also asked for ideas from the group members as to what they wanted to accomplish from the group experience.

After the initial session we encouraged the groups to move in their own direction, generally within the life review format, often beyond it. Despite the varied content of the discussions we stressed the continuity of experience and we also supported the natural movement of the group from discussion of societal similarities and differences (a good starting point) to a sharing of more personal, private and often painful experiences.

One group let us know almost immediately that their focus of concern was not on reviewing past experiences but on coping with current life stresses. This group shifted the focus from life review to "support." The second group also changed focus but what developed after early sessions utilizing the life review process was a social gathering, with participants sharing current activities and travel information. The effort of one member to deal with more personal issues was unheeded by the other members and our efforts to respond and include others who might have experienced similar problems were not successful.

Subsequent Developments: When we mentioned termination to the support group, there was a reluctance to stop meeting. After some discussion of the group direction if it were to continue, provisions were made for continuation at the Professional Psychology Center, School of Professional Psychology. The group came up with the name CAST (Caring and Sharing Together), used the word "support" to describe what they saw as the important ingredient in the group process, but also used the word "therapy" to describe what they had gotten from the group thus far. We requested that each group member call the Professional Psychology Center to request continued service. Of the eight original members, one stated definitely that she did not wish to continue but preferred to look for activities that would "keep her mind active." Still, we were surprised when six of the expected seven members were able to make the transition to the new location and agreed to pay a small fee for the services previously received gratis.

The group did reconvene at the Professional Psychology Center and continued meeting for several months, operating much like any other group. We report this development because of the implications for involvement of elderly people in mental health services. Cautions: it was difficult to recruit new members for this group; also, all continuing members had previous mental health experience and "knew what to expect." In this regard they were probably unique among their peers.

Although the two groups described chose not to remain with the Life Review format, we were struck by its potential value as a means for engaging people in therapeutic experiences. We doubt that groups described as psychotherapy groups would have similar appeal. While there should be no requirement that such groups change from life review to traditional therapy, the option is available.

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CHAPTER 5. SUMMARY AND CONCLUSIONS

Individuals from two senior centers, each within the catchment area of a mental health center, voluntarily registered for participation in "Life Exploration and Enrichment Workshops." Following a plenary session to explain the groups, those who registered completed three "Life Satisfaction Questionnaires" (described in Chapter 1). They were assigned at random to one of the three therapy groups described in Chapters 2, 3 and 4.

All groups met for eight consecutive hour-and-one-half weekly sessions. Each group had two leaders and the sessions were videotaped 1) to monitor process and progress and 2) for use in the subsequent training of mental health center staff.

The original plan proposed four groups of eight members at each center. The fourth group was to have served as a non-intervention control group and as a "waiting list" for mental health center staff intervention following training. Attendance at the explanatory sessions did not meet expectation, however, despite widespread publicity. The treatment groups were smaller than expected at both centers and at one center the T.A. group disbanded following two withdrawals, with the one remaining member joining the discussion group.

Therefore, controls were recruited from each senior center by the center personnel. Each person filled out the "Life Satisfaction Questionnaires" before and after an eight-week interval. We discovered that most of the controls were not only participants in center activities but were also volunteers at each center (e.g., R.S.V.P, class teachers), a finding relevant for the test results.

An additional set of data was gathered as the project progressed because after designing this project and gathering the pre-post test results from the first series of groups, we became interested in knowing how highly functioning nursing home residents compared with the community senior center participants. The literature indicates that a substantial number of older persons suffer from anxiety and depression. These conditions are frequently accompanied by disorientation and confusion, symptoms often mistakenly identified by health care professionals as "senility." This diagnosis often leads to placement in a nursing home. We wondered if cognitive therapies would be effective with this group of the elderly.

To explore this question in relationship to the project, we asked the administrators of two nursing homes in one mental health center catchment area to each identify ten residents whom they considered relatively intact and to whom they could administer our "Life Satisfaction Questionnaires" before and after an eight-week interval. Data is included in the results which follow.

Following completion of direct service to the groups at each center, we began a training program for mental health center staff members. We used the contents of this manual along with illustrative videotaped segments of the therapy groups. Twelve staff members received training. Since staff members indicated a particular interest in CRT, our focus was primarily on this intervention. One mental health center has successfully implemented a CRT group of 10 seniors at the senior center in its catchment area; the other would

like to do so, but their effort has been curtailed by current budget and staff cuts.

Results: There were no significant differences in effectiveness when the three treatments were compared with each other. Within each therapeutic modality, however, the mean differences were in the direction of effectiveness. Table 1 indicates the pre-post mean scores on the Beck Depression Inventory (BDI) and the State-Trait Anxiety Inventory for all therapeutic modalities, as well as the mean difference scores and the mean age for group members.

Table 1

	CRT	T.A.	Discussion	Controls	Nursing Home
N=	9	6	13	16	19
BDI					
pre	10.3	7.8	13.4	5.5	10.6
post	6.2	5.3	11.2	5.9	10.1
x̄ difference score	-4.1	-2.5	-2.2	+0.4	-0.5
A-State					
pre	31.8	37.2	42.1	30.4	31.5
post	30.8	34.2	39.6	30.9	35.7
x̄ difference score	-1.0	-3.0	-2.5	+0.5	+4.2
A-Trait					
pre	35.5	37.3	43.7	32.6	35.7
post	32.0	33.5	43.1	32.8	37.1
x̄ difference score	-3.5	-3.8	-.6	+.2	-1.4
Age	67.7	65.6	63.0	65.9	81.5

The mean BDI scores diminished for all intervention modalities. Those for the controls and nursing home residents remained essentially the same. Since the range of scores varied on both pre- and post-testing from 0-28, there is a "basement-ceiling effect," i.e. those who were not depressed on pre-test did not change while those with high scores showed decreases in their scores.

Seventeen is the cut-off score for significant depression; 9 of 21 completed pre-tests had scores greater than this, and eight decreased below this level following intervention. It appears that persons who needed help were helped the most!

In comparison to the participants in the intervention groups, the controls were low at pre-test and remained at this level on post-test, attesting to their sense of well-being and activity level. Although they were center par-

ticipants, they evidently saw no need to enroll in groups to explore and enrich their lives. The three interventions diminished depression levels so that, following intervention, the CRT and T.A. participant levels were similar to control levels.

Nursing home residents' pre- and post-scores were very similar to the mean of the pre-scores for all group participants (x 10.5). This leads us to believe that groups such as we describe would be helpful in nursing home settings.

As for the STAI A-State and A-Trait scores, they diminished to some extent in the intervention groups, remained essentially the same in the controls and went up slightly for the nursing home residents. This scale has been validated primarily on younger age groups (college students). We obtained a correlation of .75 between A-State and A-Trait for our age range (63-82). The STAI Manual reports a correlation of .65. It is possible that it is more difficult for older persons to discriminate between how they "generally feel" and how they "feel right now." It may also be possible that anxiety is a fairly constant state for older persons. It appears also that depression and anxiety overlap in the elderly. Table 2 shows the correlations among the pre-post administrations of the BDI and STAI for the intervention groups.

Table 2

	BDI-Pre	BDI-Post
A-State		
pre	.58	
post		.33
A-Trait		
pre	.71	
post		.60

all significant at $< p = .05$

The relationship between the BDI scores, as a measure of depression, and the STAI scores, as measures of trait and state anxiety, diminishes between the two administrations. These significant correlations suggest that following treatment our group participants were able to better differentiate between anxiety and depression.

There was little change over time among all groups in self-reported happiness level, the number of social contacts or other activities tapped by the activities rating scale. Perhaps the time period was insufficient for change and/or the scale permits too much individual interpretation. Our participants rated themselves "very happy" both before and after the eight-week period.

Conclusions: Cognitive therapies for groups of elderly are effective in diminishing anxiety and depression. It is difficult for this cohort of older persons to seek help in either the private or public sector. However, elderly persons who are discontented may not only join but benefit from group experiences which are not labeled "therapy." The groups were drawn from the community at large and participants were presumably functioning at a satis-

factory level. As indicated, they were randomly assigned to groups. Within the groups, members ranged from no experienced depression and little anxiety to significant levels of both. While the mean scores on both instruments diminished, the persons who had the highest initial levels of depression and anxiety also had the greatest decline in these scores. Therefore, those who needed help the most were helped the most.

It was encouraging to note that the members of one group (CAST, Chapter 4) chose to continue meeting in an ongoing group at an identifiable mental health facility. It is of interest that following the first series of group meetings at one senior center, mental health center staff were able to enroll participants in another group. As peers discuss experiences with each other, it is likely that there is a ripple effect, in which mental health becomes differentiated from mental illness or the stigma of "crazy."

We have come to believe that it is initially preferable to hold groups in community recreation centers rather than in mental health centers. This avoids the stigma associated with mental health settings and it also exposes community senior center participants and staff to therapy groups for the elderly.

Mental health center staff members found the training useful and easy to apply with a group of elderly clients. They benefitted personally and professionally by exposure to and debunking of the myths of aging. They were sensitized to the possibility of working with elderly clients and expressed enthusiasm for working with these clients.

As more elderly clients apply for services and as cost effectiveness is of increasing concern, we are convinced that the methods we have described and tested will be useful to clinicians who provide services to elderly persons in the community and in long-term care settings.

APPENDIX A

ACTIVITIES OF DAILY LIVING

NAME_____ DATE_____

Please answer the following questions on the basis of your activities during the past week.

1. On the average, how many meals did you eat each day?____ How many were eaten alone?____ How many were eaten with others?____

2. About how many people did you go to visit in the past week?____ How many of these were relatives?____ Friends?____ Others?____

3. How many people came to visit you last week?____ Of these, how many were relatives?____ Friends?____ Others?____

4. About how many phone calls were made?____ How many were received?____ How many calls were with relatives?____ Friends?____ Others?____

5. On the average, how much time was spent <u>each day</u> on the following activities?

   a) Shopping or other errands? Hours____
   b) Social gatherings (Meetings, parties, etc.)? Hours____
   c) Recreation (Games, sports, etc.)? Hours____
   d) Working (volunteer or paid)? Hours____
   e) Sleeping? Hours____
   f) Solitary activities? Watching TV - Hours____ Reading - Hours____ Hobbies - Hours____ Games - Hours____ Walking - Hours____ Chores - Hours____

6. How many times did you engage in sexual activity the past week?____

7. How typical would you say the past week has been for you? (Circle one)

   Not very typical Pretty typical Very typical

8. Are you usually <u>more</u> or <u>less</u> active compared to the past week?_____

9. Overall, how happy have you been over the past week? (Circle one)

   Very unhappy Somewhat unhappy Neither happy nor unhappy

   Somewhat happy Very happy

APPENDIX B

WORKBOOK*

We've talked about the differences between events, thoughts and feelings. Here are some definitions of each:

event: anything that happens to you; events take place "out there" in the world.
thought: an attitude, opinion or belief; thoughts occur "in our heads."
feeling: an emotional state accompanied by internal bodily changes; feelings take place "in our gut." Hint: feelings are usually one-word terms like happy, sad, angry, fearful, guilty, etc.

For example:

event: I got a flat tire while driving over here.
thought: I thought, "What a pain this is!"
feeling: I was angry about the whole thing.

event: A friend invited me over for dinner.
thought: That was really nice of him!
feeling: I was happy for the rest of the day.

Here are some to try on your own. Label each one as either an event, a thought, or a feeling:

1) I was sad for the entire week. _____
2) What a terrible thing for him to say! _____
3) I got a ticket for driving without my glasses. _____
4) My husband retired a few years ago. _____
5) She's so kind to say that about me. _____
6) I was so frightened that I began to shake. _____

Give one important event that happened to you last week:

Event: _____
Feeling: _____
Thought: _____

Homework #1

Read: Pages 1-17 in Talk Sense to Yourself (TSTY)

1. Remember what we talked about in the meeting? Fill in the blanks.

"A" stands for _____
"B" stands for _____
"C" stands for _____

*The workbook has been condensed for space considerations. In reproducing this for elderly clients, use big print and plenty of space.

2. In class we gave several examples of thoughts, events and feelings. Write in what each item below is.

a) sad, elated, worried_____
b) "I hate to make mistakes . . . "_____
c) The glass fell and broke into 1000 pieces_____
d) "I shouldn't have gone out today"_____
e) "He shouldn't be so rude to me . . ."_____
f) depressed, anxious_____
g) The doctor said to rest all week_____
h) "I really feel old and helpless . . . ."_____
i) "It doesn't really matter what she said"_____
j) The plumber never came on Monday_____

3. After you read the pages in Talk Sense to Yourself, indicate which of these things are physical pain and which are psychological pain.

a)	a broken arm	physical	or	psychological
b)	an insult in words	physical	or	psychological
c)	a slap in the face	physical	or	psychological
d)	someone is late	physical	or	psychological
e)	yelling at the kids	physical	or	psychological
f)	falling down on ice	physical	or	psychological
g)	being alone too much	physical	or	psychological
h)	the death of a loved one	physical	or	psychological

4. Below are some examples where either the A (event), the B (thought) or the C (feeling/behavior) is missing. Fill in the blanks.

a) Joan is late for work and her boss scolds her.
b) _____
c) Joan feels depressed and anxious all day.

a) _____
b) "I must never make mistakes; it's terrible to make an error."
c) Guilty and depressed.

a) Mark always criticizes Mabel for overcooking the roast.
b) Mabel thinks _____
c) Mabel feels annoyed but she isn't very upset.

a) John comes home late from work to find his wife crying and scared.
b) John thinks "I should have called. I am a worm for not doing so. My wife will hate me and never trust me again."
c) _____

a) Andy makes mistakes on the typewriter.
b) _____
c) Andy feels a bit stupid but goes on to have a good time!

a) It is Gertrude's birthday and her children have not called from California to say "Happy Birthday."
b) _____
c) Gertrude feels so badly that she cries for two hours, all alone.

a) _____

b) Mae thinks, "So what if that driver cut me off and honked; I know that I drive slowly - so what! !"

c) Mae feels pretty good about herself.

Workbook Session #2

Below are the six categories of troublesome thoughts. Each has a typical sentence next to it. We want you to find the specific A, B and C that occur to you in each. Hint: Write in A and C first, do the B last. Do one example of each in class. Do the other one from each set for homework.

NAMBY PAMBY - "I can't stand it . . . "

A_____

B_____

C_____

A_____

B_____

C_____

(to reproduce, include 6 lines as shown above under the additional 5 headings below)

FAIRY TALE - "Things should be different . . . "

MONSTER - "It is dangerous . . . "

I STINK - "I'm no good . . . "

YOU STINK - "You're no good . . . "

DOOMSDAY - "It's terrible, horrible and catastrophic . . . "

Homework #2

NAME_____

Reading Assignment: pp. 18-27 in Talk Sense to Yourself.

1) Let's start out with some ABC's:

A stands for_____

B stands for_____

C stands for_____

Please identify the A, B and C of these 2 examples:

2) After 47 years in the Army, Fred was promoted to PFC. He said, "That's terrific!" and felt happy.

A:_____

B:_____

C:_____

3) While Pat was driving to work, someone cut in front of her. She said to herself, "That kind of driving is terrible. He shouldn't be allowed on the road!" She was very angry.

A:_____
B:_____
C:_____

For the following stories, supply the C:

4) A: Bonnie bought Betty lunch today.
B: Betty thought, "It's very nice of Bonnie to do this for me."
C: _____

5) A: Mary worked all day preparing dinner, but her husband didn't like it.
B: She said to herself, "He has no right to treat me like that!"
C: _____

For the next 2 examples, supply a sentence for the B:

6) A: Sally had a fight with her son and she felt angry.
B: _____

7) A: Barbara's neighbors had a party and didn't invite her so she felt rejected.
B: _____

Fill in the C's:

8) A: My daughter hasn't called or written in months.
B: People must love me or I'll be miserable.
C: _____

A: My daughter hasn't called or written in months.
B: People should do what I want when I want it!
C: _____

Workbook Session #3

Think about two situations (A's) in the last month that were upsetting. Follow the outline below. (To reproduce, add lines after each item.)

Situation #1: A - the event, what happened out there?
B - What was I thinking?
C - What was I feeling "in my gut" and doing as a result?
Now, STATE YOUR CASE - "I feel _____ because
Now, DEFINE YOUR TERMS - (use a dictionary)

Situation #2 (as above, except A - the event, B - your thought(s), C - feeling and reaction - include case and terms)

Homework #3

NAME_____

Reading Assignment: pp. 28 and 29 in Talk Sense to Yourself.

Please define the following terms (a dictionary would be helpful):

1) should:_____
2) terrible:_____
3) worthwhile:_____
4) awful:_____

5) What is the correct form for stating your case?_____

6) Why is it important to define your terms?_____

7) Give us one example (real or made up) of a situation including an event (A), thought (B) and feeling (C):

A:_____
B:_____
C:_____

8) Now state your case using the B and C you've written above:_____

9) What are the key terms you've used? Give a short definition of each:

10) Here are 5 Questions to ask yourself about the B. Circle "Yes" or "No" for each question:

1. Does the belief help me feel better? Yes No
2. Does the B help me accomplish my goals? Yes No
3. Does the B help me get along with others? Yes No
4. Would everybody have this B in my situation? Yes No
5. Do I always feel this way in such situations? Yes No

List 5 troublesome situations (A's) below and then go on to take a very close look at your thinking in each of the situations. Use the format that we have here, step by step. (to reproduce, list 1-5 with lines following)

NUMBER _____

A: _____
B: _____
C: (include feeling and action)_____
STATE YOUR CASE:
DEFINE YOUR TERMS:
Rewrite your thought clearly now:
Answer the five questions about B's (reproduce as listed above)
And now, my friend, given your answers to the questions, do you think it might be useful to change this thought pattern?
YES, I WANT TO CHANGE! ! NO, I LIKE IT THIS WAY.

As above, take the rest of the troublesome situations and analyze as you did the first. Ask the five questions and ask yourself if you want to change it or keep it. (To reproduce, repeat the format for four pages)

Session #4

A hierarchy is a system of ordering things by rank or importance. We'll be dealing with lists of events (A's) which elicit a particular feeling (C). The important features of a hierarchy are:

1) each hierarchy deals with one feeling (for example, "Guilt")
2) the different situations must be specific enough to be clearly "visualizable."
3) the ranking proceeds in small steps of "upsetness" from the least upsetting situation to the most upsetting one.
4) the distance between situations is kept equal, with no "jumps," rather a gradual increase in the target emotion as you proceed up the hierarchy.

In the space below, begin making a hierarchy for one particular feeling which is troublesome for you. Hints: the hierarchy is made of up A's which may have actually happened to you or which you imagine may happen. All of your A's will lead to a very similar C (that is, your "target emotion"). You might have a SADNESS hierarchy, an ANGER hierarchy, a GUILT hierarchy. Each emotion has a different hierarchy. There's a good example of a GUILT hierarchy in the book on p. 40.

Directions: Fill in 3 A's; the one which typically produces the most of your target emotion, one which produces only a little of it, and one which is just "in between."

HIERARCHY for _____ (the C you want to work on)

MOST	10	_____
	9	
	8	
	7	
	6	
In between	5	_____
	4	
	3	
	2	
	1	
LEAST	0	_____

Homework #4

Fill in the rest of this Hierarchy as your Homework for next time. You'll need to recopy what you've written above onto the sheet marked "HIERARCHY # _____". If you get stuck, re-read pp. 39-40 in Talk Sense. If you feel like you're hopelessly confused, talk to one of us. Hint: Make a list of many situations (A's) which produce this feeling (C). Rate each situation from 0-10, then fill in your hierarchy.

Homework #5

HIERARCHY #____

NAME_____ _____

This is my HIERARCHY for_____ (the C I want to work on)

Hint: Follow the instructions given in your WORKBOOK and/or re-read pp. 39-40 in TALK SENSE.

MOST	10	_____
	9	
	8	
	7	
	6	
IN BETWEEN	5	_____
	4	
	3	
	2	
	1	
LEAST	0	_____

Session #5

COUNTERING is a way for you to systematically attack those troublesome thoughts and replace them with more realistic and useful thoughts. There are several important rules to countering properly. Follow these closely and ask questions of your group leaders if you are not sure.

- COUNTER strongly and frequently
- expect to have second thoughts once you get going, but fight them
- use the BASIC COUNTERS if you are stuck
- counters are opposites, not compromises
- they should be statements of reality and believable

Start with the "0" item on your hierarchy and follow the format provided.

0 item A _____

B _____

COUNTERS: 1 _____
2 _____
3 _____

1 item A _____
B _____

(to reproduce, provide lines for counters 1, 2 and 3; continue in the same way for 2 item.)

Homework #6

NAME_____

In class we wrote the counters for items "0", "1" and "2". For this homework we want you to complete the bottom half of your hierarchy by doing the same for items "3", "4" and "5". Refer back to your Workbook page for tips on effective counters.

(to reproduce, use same format as for "0" item above.)

(at end) COMMENTS: (or questions)

Session #7

Procedure for Challenging

Either sit back or lie down. (pause) Close your eyes. (pause) Let all your muscles relax. Your neck . . . your shoulders . . . your arms . . . your legs. (pause) Let your whole body go loose and limp. Let yourself get very heavy. (pause) Remember that this is your time. This is your time to relax. This is your time to work on your own problems. Don't let other thoughts or other ideas interfere. Right now, take this time for yourself. To relax even further, take a deep breath, and hold it for a second . . . now exhale s l o w l y. As you exhale, let your body get twice as heavy as it is now. (pause) Take another deep breath and hold it for a second . . . now s l o w l y let it out and let yourself get even heavier. (pause) To start working on your problems, imagine the lowest remaining item on your hierarchy. Picture it clearly in your mind. Make all of the details as clear as you possibly can. Imagine what it sounds like . . . smells like . . . feels like. See all the colors and all the details. Think only about this one scene. Visualize it as fully and clearly as you can. (10 sec.)

While you are doing this, let yourself think the trouble thought that you are working on for this situation. If you feel the emotion that normally occurs, that's OK. (10 sec.) Continue to picture all the details of this situation. (10 sec.) Stop. Right now, counter the troublesome thought. Challenge and contradict it in every way that you can. Counter it with total concentration. Attack the thought! Do not let up for a second. This is a useless thought that is causing you problems—so go after it and attack it vigorously! Do this for about a minute (1 min.) Keep countering. You must concentrate 100 percent to succeed. This takes your full energies. (10 sec.)

All right, stop. Go back to the original situation. Imagine that situation in full detail. It is extremely important that you imagine this scene as clearly and as vividly as possible. Also imagine yourself stating the trouble thought in this situation. Concentrate on this for about a minute. (1 min.) Stop. Now counter the trouble thought. Concentrate totally. Why is that thought useless? Why does it hurt you and cause you problems? Why should you think differently? Work on this for about a minute. (1 min.) Keep countering just a little while longer. (10 sec.) Stop. Again, imagine the original scene and imagine yourself having the negative thought. Work on this for about a minute. (1 min.) Stop. Now this time, counter even

harder than you have before. Concentrate harder and come up with at least one new counter. Don't let up for a second! This requires your full concentration. Keep countering for about a minute. (1 min.) Stop. Open your eyes. Feel calm and wide awake.

"Trouble-shooting": There are four mistakes that can cause problems. One, you may not be concentrating strongly enough when you are countering, or imagining vividly enough when you are imagining a scene . . . Two, you must be careful never to argue with your own counters. Three, be careful, or the situation you are working on may actually involve an emotion different from the rest of the items on your hierarchy. Four, - and the most common mistake of all - is forgetting to space the items on your hierarchy equally apart. For instance, the difference between number five and number six should be the same as the difference between number eight and number nine. If you feel you have been making any of these mistakes, try this exercise again, without the mistake. If for any other reason you are having a difficult time, your therapist will be happy to help you.

Homework #7

Here is a diary sheet designed for home practice of the challenging procedure.

Date	Troublesome Thought	Discomfort Before (0-10)	Counters	Discomfort After (0-10)	Time Spent

APPENDIX C

TERMS

Adult Control: An integrative part of the personality which takes into account both Parental directives/messages and Child wants/needs. Adult control involves listening to both the Child and Parent parts of mediating so both parts are acknowledged. An example: when a talkative person decides to critically evaluate when to contribute to a conversation rather than always taking over.

Contamination: Statements that are accepted as true without examination for accuracy. Many of the myths about the elderly fall into this category. These contaminated beliefs must be reexamined and either accepted or rejected given appropriate evidence.

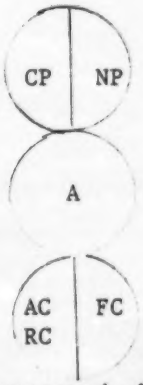
Contracting: A method for evaluating and identifying personal goals. Once the person has a goal there must be a check to see whether it comes from a Parent, Adult or Child. Contracts need to be made with the Adult in agreement with the Child. Parent contracts are usually sabotaged by a resistant Child. It is important to specify contracts in concrete behavioral terms and to review them regularly.

Ego States: Ego states are experiential realities with certain observable patterns of thoughts, feelings and behaviors. The Parent ego state is a collection of attitudes, thoughts, behaviors and feelings which are learned from parent and other authority figures. The Adult ego state is a data processor which functions as a computer, predicting events and making logical statements. The Child ego state consists of thoughts, feelings and behaviors often typical of children and spontaneous adults (Berne, 1977).

Structural Diagram

Parent
Adult
Child

Functional Diagram



Critical Parent
Nurturing Parent
Adult
Adapted or Rebellious Child
Free Child or Natural Child

A Free child ego state occurs when a person is not concerned about the reactions of parents. The adapted child may be compliant, industrious, rebellious, or act in any other way that pays off with parent figures. Critical and nurturing parent responses are typical of critical and nurturing parents!

Scripts: Motivating forces in life because they contain our life plan about how life will be and what will happen. Scripts develop at age 2 or 3 and are revised at 5 or 6. The characters are usually based on a person's family of origin with books, fairy tales and T.V. providing the script plot. Scripts are continually reviewed and revised based on newly acquired information throughout adolescence. Older persons need to examine their life scripts to see if they fit their current life.

Stroking: A unit of recognition that is necessary for survival. Strokes can be either physical (touching) or verbal (words). The stroking patterns we develop (either positive, negative, conditional or unconditional) are learned during early years as we adapt to our environment and are called a stroke economy. Self stroking includes both verbal and physical ways we recognize ourselves. Examples include bubble baths, facials, music and internal dialogues.

SOME POSITIVE ASPECTS OF GROWING OLDER

1) Gain experience

2) Growing knowledge

3) Mental Pause (use as an excuse for forgetfulness)

4) Security

5) Independence

6) Flexible eating habits, dress (don't feel you have to conform to society)

7) Enjoyment of family without the responsibility

8) Time to do things, to notice things, to enjoy!

9) Get discounts in many stores, museums, transportation, etc.

10) Family support